

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36508

STATE FILE NUMBER

FILED NOV 13 1957

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 106

1. PLACE OF DEATH a. COUNTY <i>Lafayette</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <i>Mo.</i> b. COUNTY <i>Canroll</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits <i>Lefington</i> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Canrollton</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb <i>Chas. Memorial 4 day</i>		d. STREET ADDRESS (If outside, give location) Reside on Farm <i>Route 5</i> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Chas. Marion Bryson</i>		4. DATE OF DEATH <i>Nov. 6-1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mich-17-1904</i>
9. AGE (In years last birthday) <i>53</i>		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>19</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Star Paper Route operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Saline Co. Mo.</i>	
11. BIRTHPLACE (City and state or country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Bryson</i>		14. MOTHER'S M maiden name <i>Polly Davis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Wayne Bryson, New Frankl</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
19. WAS AUTOPSY PERFORMED? <i>2</i> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		332X	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <i>11-1-57</i> to <i>11-6-57</i> and last saw <i>him</i> alive on <i>11-6-57</i> Death occurred at <i>11:36 PM</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Joe W Ward MD</i>		22b. ADDRESS <i>Lefington Mo.</i>	
22c. DATE SIGNED <i>11-7-57</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11-9-57</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>City Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Saline Mo.</i>	
24. FUNERAL DIRECTOR <i>Hill Brothers, Saline Mo</i>		25. DATE RECD. BY LOCAL REG. <i>11-8-57</i>	
26. REGISTRAR'S SIGNATURE <i>Wm. E. Eastbrook</i>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

DEC 2 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, working under my personal supervision..

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed A. C. Hill

Licensed Embalmer No. 309

P. O. Address Slater,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.